



STATE OF ALABAMA
DEPARTMENT OF VETERANS AFFAIRS
P.O. BOX 1509
MONTGOMERY, ALABAMA 36102-1509



R/ADM W. Clyde Marsh, USN, (Ret.)
Commissioner

Dear Alabama Veteran:

Thank you for your interest in the Alabama State Veterans Home Program. Our Homes provide a dignified environment to veterans who have honorably served our country, and are now in need of long term care. We would like to extend an invitation to you and your family to visit any of our State Veterans Homes to see their outstanding facilities and speak with a staff member.

The Alabama Department of Veterans Affairs (ADVA) oversees all veterans homes which are owned by the State of Alabama. State law stipulates that we hire a private health care provider to operate our veterans homes. As the owner of the homes, we oversee the contract and continually monitor the operations of our homes. Each veterans' home is licensed by the State of Alabama Department of Public Health and complies with US Department of Veterans Affairs standards for the long term care of veterans.

The ADVA receives guidance and support from the State Board of Veterans Affairs. The State Board of Veterans Affairs is comprised of thirteen wartime veterans from various service organizations across the state. Their interest is in serving fellow veterans and to assure the highest quality care is provided for those in need.

Our goal is to care for him or her who have borne the battle and continue to uphold the sacred trust that our nation bestows on its veterans.

Sincerely,

W. Clyde Marsh
Commissioner

Alabama State Veterans Home



Dear Veteran:

Thank you for your interest in the Alabama State Veterans Homes. Please review the enclosed information relative to terms of admission and discharge prior to completion of the application.

You may select one of the three Homes which best serves the needs of you and your family. This package has been assembled to provide you with the information necessary to aid us in determining eligibility and to expedite the total process. Submit the completed application directly to the home in which you are applying for admittance or you may return to your County Veterans Service Officer. The Homes are located at the following address:

- 1) Bill Nichols State Veterans Home
1784 Elkahatchee Road
Alexander City, Alabama 35010
(256) 329-3311
- 2) William F. Green State Veterans Home
300 Faulkner Drive
Bay Minette, Alabama 36507
(251) 937-8049
- 3) Floyd E. "Tut" Fann State Veterans Home
2701 Meridian Street
Huntsville, Alabama 35811
(256)851-2807

If you have any questions, contact the department representative listed above or you may contact me at:

Alabama State Department of Veterans Affairs
P.O. Box 1509
Montgomery, Alabama 36102-1509
(334) 242-5077

Sincerely,

Kimberly B. Justice
State Veterans Home Coordinator

Alabama State Veterans Home



Eligibility Requirements:

Code of Alabama, Section 31-5A-8 states, "admission to and discharges from any Alabama state veterans' home shall be in accordance with the policies and procedures as established by the State Board of Veterans Affairs at the time application for admission or for discharge is presented; provided, however, that the State Board of Veterans Affairs may admit and discharge veterans to any Alabama veterans' home who qualify for care and treatment under Title 38, U.S.C., Section 101 (19) and Section 641, may adopt appropriate rules consistent with accepted medical considerations to carry out this function." To be eligible for care from any Alabama State Veterans Home the veteran must meet the following eligibility requirements:

- Must be honorably discharged from military service with a minimum of 90 days of service, of which one day was during a wartime period. DD-214 or equivalent must be part of the application package. (no exceptions)
- Must meet the qualifications as set forth by the U.S. Department of Veterans Affairs criteria for skilled nursing care.
- Must have been a resident of the State of Alabama during the immediate past 12 months. (No exceptions) (proof of residency may be required).
- Must have had a medical examination by a physician within 90 days of admission request and exam will show that veteran does not have:
 - medical or nursing care needs for which Home is not equipped or staffed to provide.
 - behavioral traits which may prove to be dangerous to the well-being of the resident, other residents, staff or visitors.
 - a diagnosis or confirmed history of mental illness or mental retardation that outweighs their medical condition.
- Other veterans who do not have war-time service may be admitted to the Home on a space available basis. These veterans will not be placed on waiting list or placed before wartime veterans.

Note: Applicants for the State Veterans Home will be checked against the Sex Offender Registry and a background check for active felony status. Anyone found to be on the Sex Offender Registry or in a felony fugitive status shall not be considered for admission.

What the Facility Will Provide:

- Semi-private room.
- Quality food service with individual diet counseling by qualified dietetic services supervisor.
- Skilled nursing care by licensed professionals with around the clock supervision by Registered Nurses.
- Medical supervision by a Veterans Home Medical Director, a licensed physician knowledgeable in long term care.
- Initial dental examination and an annual exam thereafter.
- Social Services programs tailored to meet the individual needs of the resident.
- Activity program designed to appeal to the interests of the individual resident.
- Appropriate resident education programs.
- Prescribed pharmaceuticals provided to those veterans meeting Federal VA eligibility requirements. (co-payment may be required).
- Basic supplies for personal care, such as toothbrushes, razors, skin creams, mouth care items.
- Transportation to local activities and routine medical appointments, including transportation to VA Medical Centers during normal business hours.
- Laundry and linen services to include personal laundry.
- Around the clock security staff.
- Maintain licensure and certification standards established by the U.S. Department of Veterans Affairs (USDVA) and the Alabama Department of Public Health.
- Appropriate support groups for families and responsible parties.
- Medicare Part B Services (Medical Supplies, Therapies - Physical, Speech, Occupational, Prosthetics, Ostomy Supplies)

Alabama State Veterans Home



What the Facility Will Not Provide:

- Free nursing home care
- Acute or sub-acute care
- One-on-one care
- Dispense medications not prescribed by a physician
- Restraints requested by family members, responsible parties, or friends
- Free haircuts or permanents
- Free tobacco products
- Special adaptive appliances/devices (NOTE: we do assist in securing these items through the Federal Department of Veterans Affairs for those eligible.)
- We do not provide private TV's, telephones, radios, or TV stands
- Replacement for loss, damage or destruction of personal items
- Free cable TV
- Free ambulance service

Resident/Sponsor Responsibilities:

The below listed items are examples of non-covered charges and are the responsibility of the Resident/Sponsor. These items are not all inclusive:

- All prescribed pharmaceuticals which are not provided by federal VA pharmacy.
- Co-pays for pharmaceuticals provided by VA Pharmacy.
- Barber/Beauty Shop
- Cable TV charges
- Private telephone installation and services
- Long distance telephone and Internet access charges made on facility telephones
- Physician specialist consultation fees
- Durable Medical Equipment (including oxygen), not furnished by the Veterans Administration
- Private duty nurses and sitters
- Definitive dental treatment and repairs
- Maintenance and repair of personal property including television sets
- Non covered transportation charges
- Bed Hold charges
- Co-insurance amounts for Part B services when not covered under private insurance.

Submission of this application is acceptance by all parties of the afore mentioned services and applicable charges.

Alabama State Veterans Home



General Information

1. The term Resident is used synonymously with the term sponsor/guardian when the resident is deemed incapable of making rational decisions. Such sponsor/guardian shall be legally appointed and documentation of proof provided to the Homes at the time of application.
2. The Resident shall consent to abide by all rules and/or regulations governing the Homes and to follow the course of treatment prescribed by the Home's medical staff or outside medical consultant(s) before admission to the Home.
3. The Homes shall charge the residents for comprehensive care. Every resident shall be responsible for the full payment of the comprehensive care rate payable one month in advance, and not later than the 10th of each month thereafter. Veterans who qualify under Title 39, Part II, Chapter 17, Subchapter V will not be billed for room and board or routine services. Bedhold charges apply. Veterans must be deemed service connected disabled at 70-100%. If below 70% service connected, they must be in need of care for a condition in which they are service connected.
4. Transportation to local appointments and activities is provided. Other transportation is the responsibility of the veteran.
5. Residents shall furnish their own items of personal clothing.
6. Residents shall accept transfer to other medical facilities, including those operated by the U.S. Department of Veterans Affairs and/or State Department of Veterans Affairs, if medical condition mandates, as determined by the State Veterans Homes Medical Staff/Director.
7. Residents shall accept discharge from the Homes when medical and/or administrative review determines such action to be appropriate or warranted.
8. Residents shall recognize that the Home will be operated in full compliance with the Civil Rights Act without discrimination as to race, color, creed, religion or gender.
9. Residents may apply for all U. S. Department of Veterans Affairs benefits for which he/she may be entitled. He/she may be counseled about benefit entitlements by a representative of the Department of Veterans Affairs, (normally this will be our Veterans Service Officer in your county).
10. Residents shall also bring with them any orthopedic appliances, braces, wheelchairs, walkers, etc., which may have been issued to them by the U. S. Department of Veterans Affairs.
11. Residents are allowed 10 days per occurrence for hospitalization and 12 days annually for therapeutic leave in which the USDVA will pay per diem and no bedhold charged to residents. The facility must be at 90% occupancy and the resident must have 30 days continuous stay before this applies.
12. Failure to pay for comprehensive care will result in discharge from the Homes. The Contractor is authorized to use all applicable laws to recoup monies due the Homes for comprehensive care.
13. The Resident shall designate a beneficiary to receive all personal belongings.

Submission of this application is acceptance by all parties of the afore mentioned rules and regulations.

Application and Information Sheet and Checklist

You are encouraged to contact your local Veterans Service Officer for assistance.

<u>Description</u>	<u>To be completed by</u>
___ Personal Admission Information	Veteran or Sponsor
___ Information on Legal Residency	Veteran or Sponsor
___ VA Form 10-10EZ Application for Medical Benefits	Veteran or Sponsor
___ VA Form 10-10SH Medical Certification	Medical Physician
___ ADVA Assessment for Level of Care/Mental Illness	Medical Physician, RN, Social Worker
___ Authorization for Release of Medical Information	Veteran or Sponsor

CHECKLIST FOR INFORMATION TO BE RETURNED WITH APPLICATION

- ___ Copy of legal Power of Attorney (if appropriate)
- ___ DD Form 214 or equivalent (mandatory)
- ___ Proof of Residence (completion of page 3) or voters records, employment records, State income tax records, etc. (if questionable)

If applicant is in a long term care facility, please include the following items when returning admission packet:

- History & Physical
- Nurse's Notes (last 3 months)
- Physician Notes (last 3 months)
- Social Services Notes
- MDS & Care Plan

If applicant is in the hospital during the application process, please include the following when returning the admission packet:

- History & Physical
- Interim Summary or Discharge Summary

Notice to Applicant: The following forms: VA Form 10-10SH, 10-10EZ, ADVA Assessment for Level of Care/Mental Illness, are very detailed and require concise and accurate information to ensure your application is processed in the most efficient manner. Failure to provide the requested information could adversely affect your prospects for entering an Alabama State Veterans Home. Each form serves a specific purpose, whether it be for the Admissions Committee to determine your medical eligibility for admission or the category of skilled care you will require or for the expediting of the processing for payment of the VA Per Diem to the Home. In any case, these documents are of the utmost importance and merit your closest attention. Acceptance for admission or placement on the waiting list **will not occur until all information is received.**



Alabama State Veterans Home

TO BE COMPLETED BY: Veteran or Sponsor

APPLICATION IS HEREBY MADE FOR ADMISSION TO:

_____ (NAME OF HOME SELECTED)

Personal Information

1. APPLICANT NAME: _____ (Nickname/Alias) _____

2. VA CLAIM #: _____ SSN: _____

3. HOME ADDRESS: _____
Street Apt #

City

State

Zip

Phone No.

4. LEGAL ADDRESS (IF DIFFERENT FROM HOME ADDRESS)

5. PRESENT LOCATION OF APPLICANT:

HOME

HOSPITAL

NURSING HOME

OTHER FACILITY

IF OTHER THAN HOME, PROVIDE NAME, ADDRESS & PHONE NO. OF FACILITY.

6. NAME OF SPOUSE/RESPONSIBLE PARTY: _____

IF OTHER THAN SPOUSE, RELATION TO VETERAN: _____

ADDRESS: _____

HOME PHONE: _____ CELL PHONE: _____ WORK PHONE: _____

7. PERSONAL PHYSICIAN: _____

ADDRESS: _____

PHONE NO. _____

8. HAVE YOU EVER BEEN CONVICTED OF A FELONY? YES NO IF YES, PLEASE DESCRIBE BELOW:

9. NAME OF MEDICAL/DENTAL INSURANCE COMPANY

CARRIER: _____

ADDRESS: _____ PHONE: _____

POLICY NUMBER(S): _____ EFFECTIVE DATE: _____

10. HIGHEST LEVEL OF EDUCATION ACHIEVED: _____

11. USUAL OCCUPATION BEFORE RETIREMENT: _____ DATE LAST EMPLOYED: _____

12. DATE OF BIRTH: _____ COUNTY OF BIRTH: _____

STATE/COUNTRY OF BIRTH: _____ CURRENT AGE: _____

13. DATE ENTERED SERVICE: _____ DATE RELEASED FROM SERVICE: _____

BRANCH OF SERVICE: _____ PERIOD OF SERVICE: WAR PEACE

WWI (4/6/17-11/11/18)* WWII(12/7/41-12/31/46) KOREAN (6/27/50-1/31/55)

VIETNAM (8/5/64-5/7/75)* GULF WAR (8/20/90-Date to be set) OEF/OIF

(WWI-Russian service extends date to 4/1/20 or 7/1/21 if served (1) day during 4/6/17-11/11/18)

(VIETNAM-Start date of 2/28/61 for service "in country" before 8/5/64)

14. DESIGNEE TO RECEIVE PERSONAL EFFECTS UPON DISPOSITION IN THE EVENT OF DEATH OR INCAPACITATION AT THE TIME OF DISCHARGE.

NAME: _____

ADDRESS: _____

PHONE NUMBER(S): _____

15. DID A VETERANS SERVICE OFFICER ASSIST YOU? YES NO IF SO, WHAT COUNTY: _____

IS THE VETERAN CURRENTLY IN RECEIPT OF VA SERVICE CONNECTED DISABILITY COMPENSATION OR NON-SERVICE CONNECTED PENSION? YES NO IF SO, HOW MUCH? PENSION \$ _____ COMPENSATION \$ _____

HAS VETERAN APPLIED FOR NSC PENSION W/AID AND ATTENDANCE OR SERVICE CONNECTED DISABILITY COMPENSATION? YES NO IF SO, WHO ASSISTED WITH APPLICATION? _____

I HAVE READ AND UNDERSTAND THE TERMS AND CONDITIONS OF ADMISSIONS/DISCHARGE TO THE STATE VETERANS HOMES. I CONSENT TO ABIDE BY ALL THE RULES AND/OR REGULATIONS GOVERNING THE HOMES.

SIGNATURE OF RESIDENT/SPONSOR: _____

DATE COMPLETED: _____



Department of Veterans Affairs

APPLICATION FOR HEALTH BENEFITS

SECTION I - GENERAL INFORMATION

Federal law provides criminal penalties, including a fine and/or imprisonment for up to 5 years, for concealing a material fact or making a materially false statement. (See 18 U.S.C. 1001)

1. VETERAN'S NAME (Last, First, Middle Name)		2. OTHER NAMES USED	3. MOTHER'S MAIDEN NAME	4. GENDER <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE
5. ARE YOU SPANISH, HISPANIC, OR LATINO? <input type="checkbox"/> YES <input type="checkbox"/> NO	6. WHAT IS YOUR RACE? (You may check more than one.) (Information is required for statistical purposes only.) <input type="checkbox"/> AMERICAN INDIAN OR ALASKA NATIVE <input type="checkbox"/> BLACK OR AFRICAN AMERICAN <input type="checkbox"/> ASIAN <input type="checkbox"/> WHITE <input type="checkbox"/> NATIVE HAWAIIAN OR OTHER PACIFIC ISLANDER			
7. SOCIAL SECURITY NUMBER	8. VA CLAIM NUMBER	9. DATE OF BIRTH (mm/dd/yyyy)		
9A. PLACE OF BIRTH (City and State)		10. RELIGION		
11. PERMANENT ADDRESS (Street)	11A. CITY	11B. STATE	11C. ZIP CODE (9 digits)	
11D. COUNTY	11E. HOME TELEPHONE NUMBER (Include area code)	11F. E-MAIL ADDRESS		
11G. CELLULAR TELEPHONE NUMBER (Include area code)		12. TYPE OF BENEFIT(S) APPLYING FOR (You may check more than one) <input type="checkbox"/> ENROLLMENT/HEALTH SERVICES <input type="checkbox"/> DENTAL		
13. WHICH VA MEDICAL CENTER OR OUTPATIENT CLINIC DO YOU PREFER? (for listing of facilities visit www.va.gov/directory)		14. DO YOU WANT AN APPOINTMENT WITH A VA DOCTOR OR PROVIDER AS SOON AS ONE BECOMES AVAILABLE? <input type="checkbox"/> YES <input type="checkbox"/> NO I am only enrolling in case I need care in the future.		
15. CURRENT MARITAL STATUS (Check one) <input type="checkbox"/> MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> SEPARATED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> UNKNOWN				
16. NAME, ADDRESS AND RELATIONSHIP OF NEXT OF KIN		16A. NEXT OF KIN'S HOME TELEPHONE NUMBER (Include area code)		
		16B. NEXT OF KIN'S WORK TELEPHONE NUMBER (Include area code)		
17. NAME, ADDRESS AND RELATIONSHIP OF EMERGENCY CONTACT (if different than 16)		17A. EMERGENCY CONTACT'S HOME TELEPHONE NUMBER (Include area code)		
		17B. EMERGENCY CONTACT'S WORK TELEPHONE NUMBER (Include area code)		

SECTION II - INSURANCE INFORMATION (Use a separate sheet for additional information)

1. ENTER HEALTH INSURANCE COMPANY NAME, ADDRESS AND TELEPHONE NUMBER (include coverage through spouse or other person)				
2. NAME OF POLICY HOLDER	3. POLICY NUMBER	4. GROUP CODE	5. ARE YOU ELIGIBLE FOR MEDICAID? <input type="checkbox"/> YES <input type="checkbox"/> NO	5A. EFFECTIVE DATE (mm/dd/yyyy)
6. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART A? <input type="checkbox"/> YES <input type="checkbox"/> NO		6A. EFFECTIVE DATE (mm/dd/yyyy)		
7. ARE YOU ENROLLED IN MEDICARE HOSPITAL INSURANCE PART B? <input type="checkbox"/> YES <input type="checkbox"/> NO		7A. EFFECTIVE DATE (mm/dd/yyyy)		
8. NAME EXACTLY AS IT APPEARS ON YOUR MEDICARE CARD			9. MEDICARE CLAIM NUMBER	

APPLICATION FOR HEALTH BENEFITS, Continued	VETERAN'S NAME (Last, First, Middle)	SOCIAL SECURITY NUMBER
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SECTION VII - PREVIOUS CALENDAR YEAR GROSS ANNUAL INCOME OF VETERAN, SPOUSE AND DEPENDENT CHILDREN
(Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. GROSS ANNUAL INCOME FROM EMPLOYMENT (wages, bonuses, tips, etc.) EXCLUDING INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$
2. NET INCOME FROM YOUR FARM, RANCH, PROPERTY OR BUSINESS	\$	\$	\$
3. LIST OTHER INCOME AMOUNTS (eg., Social Security, compensation, pension interest, dividends). EXCLUDING WELFARE.	\$	\$	\$

SECTION VIII - PREVIOUS CALENDAR YEAR DEDUCTIBLE EXPENSES

1. TOTAL NON-REIMBURSED MEDICAL EXPENSES PAID BY YOU OR YOUR SPOUSE (e.g., payments for doctors, dentists, medications, Medicare, health insurance, hospital and nursing home) VA will calculate a deductible and the net medical expenses you may claim.	\$
2. AMOUNT YOU PAID LAST CALENDAR YEAR FOR FUNERAL AND BURIAL EXPENSES (INCLUDING PREPAID BURIAL EXPENSES) FOR YOUR DECEASED SPOUSE OR DEPENDENT CHILD (Also enter spouse or child's information in Section VI.)	\$
3. AMOUNT YOU PAID LAST CALENDAR YEAR FOR YOUR COLLEGE OR VOCATIONAL EDUCATIONAL EXPENSES (e.g., tuition, books, fees, materials) DO NOT LIST YOUR DEPENDENTS' EDUCATIONAL EXPENSES.	\$

SECTION IX - PREVIOUS CALENDAR YEAR NET WORTH (Use a separate sheet for additional dependents)

	VETERAN	SPOUSE	CHILD 1
1. CASH AMOUNT IN BANK ACCOUNTS (e.g., checking, savings accounts, certificates of deposit, individual retirement accounts, stocks and bonds)	\$	\$	\$
2. MARKET VALUE OF LAND AND BUILDINGS MINUS MORTGAGES AND LIENS. (e.g., second home and non-income producing property. Do not count your primary home.)	\$	\$	\$
3. VALUE OF OTHER PROPERTY OR ASSETS (e.g., art, rare coins, collectables) MINUS THE AMOUNT YOU OWE ON THESE ITEMS. INCLUDE VALUE OF FARM, RANCH OR BUSINESS ASSETS. Exclude household effects and family vehicles.	\$	\$	\$

SECTION X - PAPERWORK REDUCTION ACT AND PRIVACY ACT INFORMATION

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of Section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 45 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

Privacy Act Information: VA is asking you to provide the information on this form under 38 U.S.C. Sections 1705, 1710, 1712, and 1722 in order for VA to determine your eligibility for medical benefits. Information you supply may be verified through a computer-matching program. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices and in accordance with the VHA Notice of Privacy Practices. Providing the requested information is voluntary, but if any or all of the requested information is not provided, it may delay or result in denial of your request for health care benefits. Failure to furnish the information will not have any effect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify Veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law.

SECTION XI - CONSENT TO COPAYS

By signing this application you are agreeing to pay the applicable VA copays for treatment or services of your NSC conditions as required by law.

SECTION XII - ASSIGNMENT OF BENEFITS

I understand that pursuant to 38 U.S.C. Section 1729, VA is authorized to recover or collect from my health plan (HP) for the reasonable charges of nonservice-connected VA medical care or services furnished or provided to me. I hereby authorize payment directly to VA from any HP under which I am covered (including coverage provided under my spouse's HP) that is responsible for payment of the charges for my medical care, including benefits otherwise payable to me or my spouse.

ALL APPLICANTS MUST SIGN AND DATE THIS FORM. REFER TO INSTRUCTIONS WHICH DEFINE WHO CAN SIGN ON BEHALF OF THE VETERAN.	
SIGNATURE OF APPLICANT	DATE



**STATE HOME PROGRAM APPLICATION FOR VETERAN CARE
 MEDICAL CERTIFICATION**

PART I - ADMINISTRATIVE

STATE HOME FACILITY		DATE ADMITTED	GENDER <input type="checkbox"/> M <input type="checkbox"/> F
RESIDENT'S NAME (Last, First, Middle) (This is a mandatory field)		SOCIAL SECURITY NUMBER. (Mandatory field)	
RESIDENT'S STREET ADDRESS		AGE	DATE OF BIRTH (mm/dd/yyyy)
CITY, STATE AND ZIP CODE		ADVANCED MEDICAL DIRECTIVE <input type="checkbox"/> NO <input type="checkbox"/> YES	

PART II - HISTORY AND PHYSICAL (Use separate sheet if necessary)

HISTORY

HEIGHT	WEIGHT	TEMP	PULSE	BP	HEAD/EYES/EAR/NOSE AND THROAT
NECK					CARDIOPULMONARY
ABDOMEN					GENITOURINARY
RECTAL					EXTREMITIES
NEUROLOGICAL					ALLERGY/DRUG SENSITIVITY

X-RAY/ LAB	CHEST X-RAY	DATE (mm/dd/yyyy)	RESULTS	CBC	DATE (mm/dd/yyyy)	RESULTS
	SEROLOGY					
	URINALYSIS	DATE (mm/dd/yyyy)	ALBUMEN	SUGAR	ACETONE	

CHECK ALL BOXES THAT APPLY OR CHECK NA

IS DEMENTIA THE PRIMARY DIAGNOSIS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS THERE A DIAGNOSIS OF MENTAL ILLNESS <input type="checkbox"/> YES <input type="checkbox"/> NO	HAS RESIDENT RECEIVED MENTAL SERVICES WITHIN THE PAST 2 YEARS <input type="checkbox"/> YES <input type="checkbox"/> NO	IS CLIENT A DANGER TO SELF OR OTHERS <input type="checkbox"/> YES <input type="checkbox"/> NO
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IS THERE ANY PRESSING EVIDENCE OF MENTAL ILLNESS SUCH AS:

<input type="checkbox"/> SCHIZOPHRENIA	<input type="checkbox"/> PARANOIA	<input type="checkbox"/> OTHER PSYCHOTIC OR MENTAL DISORDERS LEADING TO CHRONIC DISABILITY
<input type="checkbox"/> MOOD SWINGS	<input type="checkbox"/> SOMATOFORM DISORDER	<input type="checkbox"/> PANIC OR SEVERE ANXIETY DISORDER
		<input type="checkbox"/> PERSONALITY DISORDER

OXYGEN <input type="checkbox"/> MASK <input type="checkbox"/> PRN <input type="checkbox"/> NASAL CANULAR <input type="checkbox"/> CONTINUOUS		<input type="checkbox"/> TUBE FEEDING <input type="checkbox"/> OSTOMY <input type="checkbox"/> TRACHOSTOMY	<input type="checkbox"/> DECUBITUS ULCERS <input type="checkbox"/> DRAINING WOUND <input type="checkbox"/> WOUND CULTURED	FOLEY CATHETER <input type="checkbox"/> TEMPORARY <input type="checkbox"/> PERMANENT
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REFERRING PHYSICIAN	PRIMARY DIAGNOSIS
SECONDARY DIAGNOSIS	TERTIARY DIAGNOSIS

TYPE OF CARE RECOMMENDED: SKILLED NURSING HOME CARE DOMICILIARY CARE ADULT HEALTH CARE HOSPITAL

MEDICATION AND TREATMENT ORDERS ON ADMISSION, CONTINUE ON SEPARATE SHEET IF NECESSARY

PRINTED OR TYPED NAME OF PRIMARY PHYSICIAN ASSIGNED	SIGNATURE OF PRIMARY PHYSICIAN ASSIGNED
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STATE HOME PROGRAM APPLICATION FOR VETERAN CARE - MEDICAL CERTIFICATION, CONTINUED

RESIDENT'S NAME (Last, First, Middle)

SOCIAL SECURITY NUMBER

EVALUATION (Select an appropriate number in each category)

COMMUNICATION	<input type="checkbox"/> 1. Transmits messages/receives information <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Nearly or totally unable	SPEECH	<input type="checkbox"/> 1. Speak clearly with others of same language <input type="checkbox"/> 2. Limited ability <input type="checkbox"/> 3. Unable to speak clearly or not at all
HEARING	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Hearing slightly impaired <input type="checkbox"/> 3. Nearly or totally unable <input type="checkbox"/> 4. Virtually/completely deaf	SIGHT	<input type="checkbox"/> 1. Good <input type="checkbox"/> 2. Vision adequate - Unable to read/see details <input type="checkbox"/> 3. Vision limited - Gross object differentiation <input type="checkbox"/> 4. Blind
TRANSFER	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Equipment only <input type="checkbox"/> 3. Supervision only <input type="checkbox"/> 4. Requires human transfer w/wo equipment <input type="checkbox"/> 5. Bedfast	AMBULATION	<input type="checkbox"/> 1. Independence w/wo assistive device <input type="checkbox"/> 2. Walks with supervision <input type="checkbox"/> 3. Walks with continuous human support <input type="checkbox"/> 4. Bed to chair (total help) <input type="checkbox"/> 5. Bedfast
ENDURANCE	<input type="checkbox"/> 1. Tolerates distances (250 feet sustained activity) <input type="checkbox"/> 2. Needs intermitten rest <input type="checkbox"/> 3. Rarely tolerates short activities <input type="checkbox"/> 4. No tolerance	MENTAL AND BEHAVIOR STATUS	<input type="checkbox"/> 1. Alert <input type="checkbox"/> 2. Confused <input type="checkbox"/> 3. Disoriented <input type="checkbox"/> 4. Comatose <input type="checkbox"/> 5. Agreeable <input type="checkbox"/> 6. Disruptive <input type="checkbox"/> 7. Apathetic <input type="checkbox"/> 8. Well motivated
TOILETING	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Assistance to and from and transfer <input type="checkbox"/> 3. Total assistance including personal hygiene, help with clothes <input type="checkbox"/> A. Bathroom <input type="checkbox"/> B. Bedside commode <input type="checkbox"/> C. Bedpan	BATHING	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Supervision Only <input type="checkbox"/> 3. Assistance <input type="checkbox"/> 4. Is bathed <input type="checkbox"/> A. Tub <input type="checkbox"/> B. Shower <input type="checkbox"/> C. Sponge bath
DRESSING	<input type="checkbox"/> 1. Dresses self <input type="checkbox"/> 2. Minor assistance <input type="checkbox"/> 3. Needs help to complete dressing <input type="checkbox"/> 4. Has to be dressed	FEEDING	<input type="checkbox"/> 1. No assistance <input type="checkbox"/> 2. Minor assistance, needs tray set up only <input type="checkbox"/> 3. Help feeding/encouraging <input type="checkbox"/> 4. Is fed
BLADDER CONTROL	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Catheter, indwelling	BOWEL CONTROL	<input type="checkbox"/> 1. Continent <input type="checkbox"/> 2. Rarely incontinent <input type="checkbox"/> 3. Occasional - once/week or less <input type="checkbox"/> 4. Frequent - up to once a day <input type="checkbox"/> 5. Total incontinence <input type="checkbox"/> 6. Ostomy
SKIN CONDITION	<input type="checkbox"/> 1. Intact <input type="checkbox"/> 2. Dry/Fragile <input type="checkbox"/> 3. Irritations (Rash) <input type="checkbox"/> 4. Open wound <input type="checkbox"/> 5. Decubitus Number _____ Stage _____	WHEEL CHAIR USE	<input type="checkbox"/> 1. Independence <input type="checkbox"/> 2. Assistance in difficult maneuvering <input type="checkbox"/> 3. Wheels a few feet <input type="checkbox"/> 4. Unable to use <input type="checkbox"/> NA

SIGNATURE OF REGISTERED NURSE OR REFERRING PHYSICIAN

DATE

PHYSICAL THERAPY (To be completed by Physical Therapist or Referring Physician) NEW REFERRAL CONTINUATION OF THERAPY

SENSATION IMPAIRED	RESTRICT ACTIVITY	PRECAUTIONS	FREQUENCY OF TREATMENT
<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> CARDIAC <input type="checkbox"/> OTHER (Specify)	
TREATMENT GOALS: <input type="checkbox"/> ACTIVE <input type="checkbox"/> COORDINATING ACTIVITIES <input type="checkbox"/> FULL WEIGHT BEARING <input type="checkbox"/> WHEELCHAIR INDEPENDENT <input type="checkbox"/> STRETCHING <input type="checkbox"/> ACTIVE ASSISTIVE <input type="checkbox"/> NON-WEIGHT BEARING <input type="checkbox"/> PROGRESS BED TO WHEELCHAIR <input type="checkbox"/> COMPLETE AMBULATION <input type="checkbox"/> PASSIVE ROM <input type="checkbox"/> PROGRESSIVE RESISTIVE <input type="checkbox"/> PARTIAL WEIGHT BEARING <input type="checkbox"/> RECOVERY TO FUL FUNCTION			

ADDITIONAL THERAPIES <input type="checkbox"/> O.T. <input type="checkbox"/> SPEECH <input type="checkbox"/> DIETARY	SIGNATURE OF AND TITLE OF THERAPIST	DATE
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SOCIAL WORK ASSESSMENT (To be completed by Social Worker)

PRIOR LIVING ARRANGEMENTS	LONG RANGE PLAN
ADJUSTMENT TO ILLNESS OR DISABILITY	SIGNATURE OF SOCIAL WORKER
	DATE

VA AUTHORIZATION FOR PAYMENT

DATE RECEIVED BY VA	ELIGIBILITY FOR PER DIEM PAYMENT	LEVEL OF CARE RECOMMENDED
	<input type="checkbox"/> APPROVED <input type="checkbox"/> DISAPPROVED	<input type="checkbox"/> NHC <input type="checkbox"/> DOMICILIARY <input type="checkbox"/> HOSPITAL <input type="checkbox"/> ADHC
APPROVED FOR 70% SERVICE CONNECTED DISABILITY	APPROVED FOR ADMITANCE BECAUSE OF SERVICE CONNECTED ILLNESS (IF LESS THAN 70%) ILLNESS:	
<input type="checkbox"/> YES <input type="checkbox"/> NO		
SIGNATURE OF VA OFFICIAL	DATE	SIGNATURE OF VA PHYSICIAN
		DATE

PAPERWORK REDUCTION ACT AND PRIVACY ACT NOTICE

The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 30 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form. The information requested on this form is solicited under the authority of Title 38, U.S.C., Sections 1741, 1742 and 1743. It is being collected to enable us to determine your eligibility for medical benefits in the State Home Program and will be used for that purpose. The income and eligibility you supply may be verified through a computer matching program at any time and information may be disclosed outside the VA as permitted by law; possible disclosures include those described in the "routine uses" identified in the VA system of records 24VA136, Patient Medical Record-VA, published in the Federal Register in accordance with the Privacy Act of 1974. Disclosure is voluntary; however, the information is required in order for us to determine your eligibility for the medical benefit for which you have applied. Failure to furnish the information will have no adverse affect on any other benefits to which you may be entitled. Disclosure of Social Security number(s) of those for whom benefits are claimed is requested under the authority of Title 38, U.S.C., and is voluntary. Social Security numbers will be used in the administration of veterans benefits, in the identification of veterans or persons claiming or receiving VA benefits and their records and may be used for other purposes where authorized by Title 38, U.S.C., and the Privacy Act of 1974 (5 U.S.C. 552a) or where required by other statute.

VA FORM
APR 2009

10-10SH

ADVA ASSESSMENT FOR LEVEL OF CARE/MENTAL ILLNESS

Please Print in Ink

Completed by: RN, Social Worker or Physician

NAME: _____ SS#: _____ DOB: _____

CURRENT LOCATION: _____
Street City State Zip Code

LEGAL GUARDIAN (If applicable):

Name: _____ Address: _____
ATTENDING PHYSICIAN:
(Name & Address) _____

DISCHARGING HOSPITAL: _____
(Name and Address of Hospital)

ADMITTING RETAINING NURSING FACILITY NAME: Admit Date, if applicable: _____
(Name & Address) _____

1. ADMITTING DIAGNOSIS: _____ SIGNIFICANT MEDICAL PROBLEMS: _____
Primary: _____
Secondary: _____

2. BEHAVIOR ADJUSTMENT (Check all those that apply):
 Anxious Disoriented (Person, Place, Time, Situation)
 Confused Combative, Describe: _____
 Delusional Agitated, Describe: _____
 Hallucinates Self Abusive, Describe: _____
 Wanders Seizures
 Depressed None of the Above

3. SENSORY/COMMUNICATION
 Hearing Impaired Cannot Communicate, Describe: _____
 Vision Impaired Requires Assistance to Communicate, Describe: _____
 Mute _____

4. PSYCHOTROPIC, ANTI-DEPRESSANT & ANTI-ANXIETY MEDICATIONS (Identify medication name and the corresponding diagnosis for the medication):

5. NEED FOR NURSING FACILITY LEVEL OF CARE, (Check the specific services that this individual requires on a regular basis. It is imperative that a resident must meet two (2) criteria):

 Administration of a potent and dangerous injectable medication and intravenous medication and solutions on a daily basis or administration of routine oral medications, eye drops, or ointment
 Restorative nursing procedures (such as gait training and bowel and bladder training) in the case of residents who are determined to have restorative potential and can benefit from the training on a daily basis per physician's orders.
 Nasopharyngeal aspiration required for the maintenance of a clear airway.
 Maintenance of tracheostomy, gastrostomy, colostomy, ileostomy, and other tubes indwelling in body cavities as an adjunct to active treatment for rehabilitation of disease for which the stoma was created.
 Administration of tube feedings by naso-gastric tube.
 Care of extensive decubitus ulcers or other widespread skin disorders.
 Other specified and individual justified services, including observation of unstable medical conditions required on a regular and continuing basis that can only be provided by or under the direction of a registered nurse. Specify: _____

 Use of oxygen on a regular or continuous basis.
 Application of dressing involving prescription medications and aseptic techniques and/or changing of dressing in noninfected, postoperative, or chronic conditions per physician's orders.
 Comatose resident receiving routine medical treatment.

VETERAN NAME: _____ SSN: _____

6. Is the individual applying to nursing home care due to one of the following conditions? Yes No

If "Yes" please check the condition.

- Need for Convalescent Care of 120 days or less as prescribed by physician.
- Terminal illness with life expectancy of six months or less
- Comatose
- Ventilator Dependent
- Functioning only at Brain Stem Level
- Cerebellar Degeneration
- Advanced Amolytrophic Lateral Sclerosis
- Huntington's Disease

7. Does the individual have a diagnosis of Alzheimer's Disease or Dementia in the absence of Mental Retardation or a primary diagnosis of Mental Illness? Yes No

8. SUSPECTED MENTAL ILLNESS (Please check all diagnosis that apply):

- | | | |
|---|--|--|
| <input type="checkbox"/> Schizophrenia | <input type="checkbox"/> Somatoform Disorder | <input type="checkbox"/> Mood Disorder |
| <input type="checkbox"/> Personality Disorder | <input type="checkbox"/> Paranoid Disorder | <input type="checkbox"/> Other Psychotic Disorder |
| <input type="checkbox"/> Panic Disorder | <input type="checkbox"/> Other Severe Anxiety Disorder | <input type="checkbox"/> Unspecified Mental Disorder that may lead to chronic disability |

A. LEVEL OF IMPAIRMENT DUE TO THE ABOVE SUSPECTED MENTAL ILLNESS

Does the above noted disorder result in functional limitations in major life activities within the past 3-6 months with:

1. Difficulty in interpersonal functioning? Yes No
2. Serious difficulty in concentration, persistence and pace? Yes No
3. Serious adaptation to change? Yes No

B. DURATION OF ABOVE NOTED ILLNESS:

Has the individual had:

1. Psychiatric treatment more intensive than outpatient care more than once in the last 5 years? Yes No If Yes, Give name of facility: _____
2. Within the last 5 years, due to the mental disorder, experienced an episode of significant disruption to the normal living situation? Yes No (If Yes, please describe): _____

9. SUSPECTED MENTAL RETARDATION/RELATED CONDITION (Please check all diagnosis that apply. If none, proceed to Number 10):

- Mental Retardation Cerebral Palsy or Epilepsy
- Any other condition, other than MI or Dementia, found to be closely related to MR because the condition results in impairment of general intellectual functioning or adaptive behavior similar to that of persons with MR (including autism).
 - a. Was the above condition manifested before (check one):
 Age 18 Age 22 Age of Onset Unknown OR After 22nd birthdate
 - b. Is the condition likely to continue indefinitely? Yes No
 - c. The condition results in substantial functional limitations in the following areas of major life activity (check all that apply):
 Self Care Learning Understanding and Use of Language
 Mobility Direction Capacity for Independent Living

10. DANGEROUSNESS

Is the individual combative? Yes No If Yes, describe: _____

Is the individual suicidal? Yes No If Yes, describe: _____

11. CERTIFICATION

I certify that the above information is correct to the best of my knowledge.

Physician, RN or Social Worker's Signature

Date

12. Referral Source: _____ Phone: _____

Alabama State Veterans Home

TO BE COMPLETED BY: Veteran or Sponsor

Authorization for Release of Medical Information

(Applicant/Sponsor complete Part A only)

A. I hereby authorize the _____

to release medical records or other information regarding my treatment, hospitalization, and/or outpatient care to Alabama Department of Veterans Affairs. I understand that this authorization may be revoked at any time and that it will automatically expire within twelve months from the date of signing.

Please check the Veterans Home requesting information:

- | | | |
|--|--|--|
| <input type="checkbox"/> Bill Nichols
1784 Elkahatchee Road
Alexander City, AL 35010 | <input type="checkbox"/> William F. Green
300 Faulkner Drive
Bay Minette, AL 36507 | <input type="checkbox"/> Floyd E. "Tut" Fann
2701 Meridian Street
Huntsville, AL 35811 |
|--|--|--|

Witness Signature

Patient/Sponsor Signature

Date

Date

B. FOR FACILITY USE ONLY

RE:

Patient's Name

Date of Birth

Social Security Number

VA Claim Number

Dear Correspondence Secretary:

The above named patient is currently being treated or has made application for admission to one of the Alabama State Veterans Home and gives a history of having been a patient at your facility. In order to provide optimal care, the patient or applicant authorizes that his/her medical records be released to our office. Please forward a copy of:

Complete Medical Records: _____ Medical X-Rays: _____

Discharge Summary: _____ Dates: _____